I. FAMILY PLANNING SERVICES EXTENSION PROGRAM

Description. AHCCCS covers comprehensive family planning services through the Family Planning Services Extension Program for SOBRA women whose eligibility has terminated, who are not eligible for any other AHCCCS services, and who voluntarily choose to delay or prevent pregnancy. These services may be provided for up to 24 months following date of delivery. Any medical service not included in the Family Planning Services Extension Program is not covered.

Refer to Chapter 400, Policy 420 for a complete discussion of the Family Planning Services Extension Program.

J. HOME HEALTH

Description. All home health services require PA from the AHCCCS/DFSM/PA Unit.

Refer to Chapter 300, Policy 310, for complete information regarding covered home health services.

Procedures. PA requests for home health services should be submitted by mail, fax, or telephone prior to providing services.

K. HOSPITAL INPATIENT SERVICE AUTHORIZATION

Description.

Hospital inpatient service authorization is a part of the utilization management process that may consist of both PA and continued authorization, contingent upon concurrent review findings (refer to Policy 810).

Procedures.

Initial Service Authorization:

Under 9 A.A.C. 22, Article 2, the provider must notify the Administration no later than 72 hours after a FFS member receiving emergency medical services presents to a hospital for inpatient services. The Administration may deny payment for failure to provide timely notice.

1. Providers must obtain PA from the AHCCCS Administration for the following inpatient hospital services:

   a. Organ and tissue transplantations (this authorization review is performed by the AHCCCS Transplant Coordinator, DHCM, Medical Management Unit, with the exception of corneal transplants and bone grafts that are submitted to the AHCCCS/DFSM.PA Unit.)

   b. Non-emergency admissions, including psychiatric hospitalizations

   c. Elective surgery, excluding a voluntary sterilization procedure, and

   d. Services or items furnished to cosmetically reconstruct appearance after the onset of trauma or serious injury.

2. Women and their newborns may receive up to 48 hours of inpatient hospital care after a normal vaginal delivery and up to 96 hours of inpatient care after a cesarean delivery. The attending health care provider, in consultation with the mother, may discharge the mother or newborn prior to the minimum length of stay.

3. For retrospectively eligible members, notification requirements are as follows:

   a. When the member is made eligible while still in the hospital, providers must notify the Administration no later than 72 hours after the eligibility posting date for emergency hospitalizations.

   b. When eligibility is posted after the member is discharged from the hospital, the notification requirement in 3(a) will be waived.

4. Payment for services may be denied if the hospital fails to provide timely notification or obtain the required authorization number(s) within the parameters specified in this policy. However, the issuance of an authorization number does not guarantee payment; documentation provided from the member's medical record must support the diagnosis for which the authorization was issued, and the claim must meet clean claims submission requirements.

   Refer to the AHCCCS Fee-for-Service Provider Manual for information regarding pre-payment review criteria and submission requirements. This manual is available online at the AHCCCS Web site.